Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GARLAND COMMUNITY HOSPITAL
2692 WEST WALNUT 214
GARLAND TX 75042

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-98-D325-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are appealing the decision to deny this admission as not authorized. Patient was admitted thru the Emergency Room and also this was a weekend. Please review the attached records and remit payment for this admit. The original denial letter has been lost."

Amount in Dispute: $832.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute appears to involve the Fund's denial of payment for a non-authorized stay at Garland Community Hospital from 8/29/97 through 8/30/97. The requester billed the Fund $2035.50; the Fund paid $00.00 and used exception code 'A'." "Commission Rule 134.600(h)(1) states all non-emergency hospitalizations require preauthorization." "Review of the Fund's claim file shows no preauthorization request from the requester, the treating doctor or his designee, or the claimant. The same review reveals no grant of preauthorization for the disputed service." "There is no evidence in the Fund's claim file or in the requester's TWCC-60 information identifying the claimant was admitted as a result of a medical emergency." "The requester's documentation identifies the admitting diagnosis was cervicalgia, 723.1." "The nurses' notes from the requester's TREATMENT RECORD, dated 8/29/97, identifies the admission as 'NON-URGENT'."

Response Submitted by: TWCIF, 221 West 6th Street, Suite 300, Austin, TX 78701-3403

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 1997 through August 30, 1997	Inpatient Services	$832.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective April 1, 1997, requires preauthorization for non-emergency hospitalizations.
3. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
4. This request for medical fee dispute resolution was received by the Division on July 2, 1998.
5. Neither party to this dispute submitted copies of explanation of benefits to support the respondent's reduction of payment for the disputed services.

Findings

1. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of explanation of benefits or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
2. 28 Texas Administrative Code §134.600(a)(1) states "the insurance carrier is liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subsection (h) of this section, required to treat a compensable injury, when any of the following situations occur: (1) there is a documented life-threatening degree of a medical emergency necessitating one of the treatments or services listed in subsection (h) of this section."

   The submitted documentation does not support a documented life-threatening degree of a medical emergency; therefore, the disputed services required preauthorization in accordance with 28 Texas Administrative Code §134.600.
3. 28 Texas Administrative Code §134.600(h)(1) states "The health care treatments and services requiring preauthorization are: (1) all non-emergency hospitalizations, ambulatory surgical center care, and transfers between facilities." Even though explanation of benefits were not submitted for review, both parties agree that the disputed services were denied due to lack of preauthorization for the hospitalization.

   The requestor did not submit documentation to support that the disputed services were preauthorized in accordance with Administrative Code §134.600; therefore, reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/29/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.